

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-035455

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 73 Primary Registration District No. 5291 Registrar's No. 111

FILED OCT 1 1963

1. PLACE OF DEATH a. COUNTY <u>Clay</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Clay</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Kansas City Liberty Mo.</u> Length of stay in lb <u>50 yrs.</u>		c. CITY OR TOWN <u>Liberty</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) <u>I 35 + Union Rd.</u> Inside limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS <u>37 Moss</u> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM H. GOODSON, sr</u>			4. DATE OF DEATH Month Day Year <u>Sept. 22 1963</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (last birthday) <u>81</u>	IF UNDER 1 YEAR Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Medical Doctor</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>General Practice New Canaan Mo.</u>	11. BIRTHPLACE (City and state or country) <u>U.S.A.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Grandison Goodson</u>	13b. MOTHER'S MAIDEN NAME <u>Missouri Hammach</u>	14. NAME OF HUSBAND OR WIFE <u>Luella H. Goodson</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY NO. <u>[REDACTED]</u>	17. INFORMANT Address <u>Dr. Wm H. Goodson Jr. K.P. Mo.</u>
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18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crushed Chest. Multiple fracture of legs.</u> DUE TO (b) <u>One Car Accident</u> DUE TO (c) <u>One Car Accident</u>		INTERVAL BETWEEN ONSET AND DEATH <u>20.4</u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour <u>7:30</u> Month, Day, Year <u>9-22-63</u>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Highway 69 + Union Rd.</u>	20f. CITY, TOWN, OR LOCATION <u>Kansas City</u>	COUNTY <u>Clay</u>	STATE <u>Mo</u>
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21. I attended the deceased from _____ to _____ and last saw him/her alive on _____	Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <u>D. A. Pace M.D. Professor</u>	ADDRESS <u>North Kansas City Mo.</u>	22c. DATE SIGNED <u>9/22/63</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Sept 25, 1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rainier Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Liberty Missouri</u>
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24. MINERAL DIRECTOR <u>Charles A. [REDACTED] Liberty Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>9-25-63</u>	26. REGISTRAR'S SIGNATURE <u>Nabel Gra Ham</u>
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(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK  
OR  
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS 300  
Rev. 4/59  
1 6000  
2 6003  
3  
4 0  
5 2  
6  
7 0  
8 2  
9 X  
10  
11 600  
12 91-3  
13 3-0

OCT 29 1963

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed \_\_\_\_\_

Licensed Embalmer No. 4448

P. O. Address Berkeley, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.